
ENGROSSED SECOND SUBSTITUTE HOUSE BILL 1569

State of Washington

60th Legislature

2007 Regular Session

By House Committee on Appropriations (originally sponsored by Representatives Cody, Campbell, Morrell, Linville, Moeller, Green, Seaquist, Conway, Dickerson, Appleton, McIntire, McCoy, Kagi, Pedersen, Kenney, Lantz, Santos, Wood and Ormsby)

READ FIRST TIME 03/05/07.

1 AN ACT Relating to reforming the health care system in Washington
2 state; amending RCW 48.43.005, 48.43.015, 48.43.025, 48.43.035,
3 48.21.047, 48.44.024, 48.46.068, and 48.43.028; adding new sections to
4 chapter 48.43 RCW; adding a new chapter to Title 41 RCW; adding a new
5 chapter to Title 49 RCW; creating new sections; repealing RCW
6 48.21.045, 48.44.023, 48.46.066, 70.47A.010, 70.47A.020, 70.47A.030,
7 70.47A.040, 70.47A.050, 70.47A.060, 70.47A.070, 70.47A.080, 70.47A.090,
8 and 70.47A.900; and providing effective dates.

9 BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF WASHINGTON:

10 **PART I: FINDINGS AND INTENT**

11 NEW SECTION. **Sec. 101.** LEGISLATIVE FINDINGS. The legislature
12 finds that:

13 (1) The people of Washington have expressed strong concerns about
14 health care costs and access to needed health services. Even if
15 currently insured, they are not confident that they will continue to
16 have health insurance coverage in the future and feel that they are
17 getting less, but spending more.

1 (2) Many employers, especially small employers, struggle with the
2 cost of providing employer-sponsored health insurance coverage to their
3 employees, while others are unable to offer employer-sponsored health
4 insurance due to its high cost.

5 (3) Six hundred thousand Washingtonians are uninsured.
6 Three-quarters work or have a working family member; two-thirds have
7 incomes below two hundred percent of the federal poverty level; and
8 one-half are young adults age nineteen to thirty-four. Many are
9 low-wage workers who are not offered, or eligible for,
10 employer-sponsored coverage. Others struggle to pay their share of the
11 costs of employer-sponsored health insurance, while still others turn
12 down their employer's offer of coverage due to its costs. By failing
13 to make health insurance coverage affordable for low-wage workers and
14 self-employed people, health problems that could be treated in a
15 doctor's office are treated in the emergency room or hospital.

16 (4) The workforce in Washington state has undergone many changes in
17 the last three decades. Employment has shifted from manufacturing to
18 service-providing industries, a rising share of workers are employed by
19 small employers, and a growing number of people are self-employed,
20 temporary or contract workers, or work for multiple employers.

21 (5) Access to health insurance and other health care spending has
22 resulted in improved health for many Washingtonians. Yet, the
23 Washington state blue ribbon commission on health care costs and access
24 recently found that health purchasers and carriers should focus efforts
25 on receiving more value for each health care dollar spent in Washington
26 state through efforts such as paying for care that has proven value,
27 focusing on prevention and management of chronic disease, and providing
28 consumers incentives to use quality health care providers and systems.

29 NEW SECTION. **Sec. 102.** LEGISLATIVE INTENT. The legislature
30 intends, through the public/private partnership reflected in this act,
31 to improve the current health care system so that:

32 (1) Health insurance coverage is more affordable for employers,
33 employees, self-employed people, and other individuals;

34 (2) The process of choosing and purchasing health insurance
35 coverage is well-informed, clearer, and simpler;

36 (3) Prevention, chronic care management, wellness, and improved

1 quality of care are integral and valued parts of the health insurance
2 system; and

3 (4) As a result of these changes, more people in Washington state
4 have access to affordable health insurance coverage and health outcomes
5 in Washington state are improved.

6 **PART II: WASHINGTON HEALTH INSURANCE PARTNERSHIP**

7 NEW SECTION. **Sec. 201.** The definitions in this section apply
8 throughout this chapter unless the context clearly requires otherwise.

9 (1) "Administrator" means the administrator of the health care
10 authority as defined in RCW 41.05.011.

11 (2) "Authority" means the health care authority established in
12 chapter 41.05 RCW.

13 (3) "Basic health plan" means the program administered under
14 chapter 70.47 RCW.

15 (4) "Carrier" means a carrier as defined in RCW 48.43.005.

16 (5) "Commissioner" means the insurance commissioner established
17 under RCW 48.02.010.

18 (6) "Health plan" or "health benefit plan" means a health plan or
19 health benefit plan as defined in RCW 48.43.005.

20 (7) "Participating small employer plan" means a group health plan,
21 as defined in federal law, Sec. 706 of ERISA (29 U.S.C. Sec. 1167),
22 that is sponsored by a small employer and for which the plan sponsor
23 has entered into an agreement with the partnership, in accordance with
24 this act, for the partnership to offer and administer health insurance
25 benefits for enrollees in the plan.

26 (8) "Partnership" means the Washington health insurance partnership
27 established in sections 202 and 203 of this act.

28 (9) "Partnership board" and "board" means the board of the
29 Washington health insurance partnership established in section 204 of
30 this act.

31 (10) "Partnership participant" means a person who has been
32 determined by the Washington health insurance partnership to be, and
33 continues to be, an employee of a participating small employer plan for
34 purposes of obtaining coverage through the partnership, or a former
35 employee of a participating small employer plan who chooses to continue

1 receiving coverage through the partnership following separation from
2 employment.

3 (11) "Premium assistance payment" means a payment made to carriers
4 by the partnership as provided in section 205 of this act.

5 (12) "Small group" or "small employer" means a small group or small
6 employer as defined in RCW 48.43.005.

7 (13) "Successful bidder" means the entity that is chosen to operate
8 the Washington health insurance partnership as a result of the
9 procurement in sections 202 and 203 of this act.

10 NEW SECTION. **Sec. 202.** REQUEST FOR PROPOSAL TO OPERATE THE
11 WASHINGTON HEALTH INSURANCE PARTNERSHIP. (1) On or before December 30,
12 2007, in consultation with and upon approval by the board established
13 in section 204 of this act, the authority shall develop a request for
14 proposal to establish and operate a Washington health insurance
15 partnership. The partnership shall be designed to serve as a
16 statewide, public-private partnership, offering maximum value for
17 Washington state residents, through which small group health plans may
18 be bought and sold. Private entities may respond to the request for
19 proposal.

20 (2) It is the goal of the partnership to:

21 (a) Ensure that employees of small businesses and other individuals
22 can find affordable health plans;

23 (b) Provide a mechanism for small businesses to contribute to their
24 employees' coverage without the administrative burden of directly
25 shopping or contracting for a health plan;

26 (c) Ensure that individuals can access coverage as they change
27 and/or work in multiple jobs; and

28 (d) Provide a mechanism for low-income workers to obtain affordable
29 coverage through competition among carriers in the partnership, and
30 premium assistance payments as available.

31 (3) The health care authority shall submit a summary of the request
32 for proposal and the report required by subsection (4) of this section
33 to the governor and the appropriate committees of the senate and house
34 of representatives on or before January 1, 2008. If the legislature
35 does not take affirmative action to reject or modify the request for
36 proposal during the 2008 regular legislative session, the administrator
37 shall issue the request for proposal on April 1, 2008.

1 (4) The authority, in collaboration with the office of the
2 insurance commissioner and the partnership board, upon appointment,
3 shall analyze the following issues and provide a report and
4 recommendations to the appropriate committees of the senate and house
5 of representatives by January 1, 2008:

6 (a) The impact of applying small group health plan rating rules to
7 a market in which each employee chooses their health plan;

8 (b) Options that reduce uncertainty for carriers and provide for
9 efficient risk management of high-cost participants or small employer
10 plans through risk adjustment, reinsurance, or any other effective
11 mechanism; and

12 (c) Other issues identified by the partnership board as potential
13 barriers to a successful transition of the small group market to the
14 partnership.

15 NEW SECTION. **Sec. 203.** CONTENTS OF THE REQUEST FOR PROPOSAL. The
16 request for proposal issued under section 202 of this act shall
17 include:

18 (1) The appropriate qualifications for operation of the Washington
19 health insurance partnership;

20 (2) Key functions of the partnership, including but not limited to:

21 (a) Offering choice among any small group health plan approved by
22 the commissioner under Title 48 RCW. The choice of health plans shall
23 include one or more limited health care service plans for dental care
24 services to be offered by limited health care service contractors under
25 RCW 48.44.035;

26 (b) Establishing enrollment procedures, including publicizing the
27 existence of the partnership and disseminating information on
28 enrollment, and establishing rules related to minimum participation of
29 employees in small groups purchasing health insurance through the
30 partnership;

31 (c) Establishing and administering procedures for the election of
32 coverage by partnership participants during open enrollment periods and
33 outside of open enrollment periods upon the occurrence of any
34 qualifying event specified in the federal health insurance portability
35 and accountability act of 1996 or applicable state law;

36 (d) Establishing and managing a system for the partnership to be
37 designated as the sponsor or administrator of a participating small

1 employer plan and to undertake the obligations required of a plan
2 administrator under federal law. The small employer shall determine
3 the criteria for eligibility and enrollment in his or her plan and the
4 terms and amounts of the employer's contributions to that plan.
5 Neither the employer nor the partnership shall limit an employee's
6 choice of coverage from among all the health plans offered;

7 (e) Establishing and managing a system of collecting and
8 transmitting to the applicable carriers all premium payments or
9 contributions made by or on behalf of partnership participants,
10 including employer contributions, automatic payroll deductions for
11 partnership participants enrolled in small employer plans, premium
12 assistance payments under section 205 of this act, and contributions
13 from philanthropies;

14 (f) Establishing and managing a system for determining eligibility
15 for premium assistance payments and remitting premium assistance
16 payments to the carriers, as provided in section 205 of this act;

17 (g) Assessing the need for mechanisms to spread health risk widely
18 to support health plan premiums that are more affordable, and
19 establishing opportunities to reward carriers and consumers whose
20 behavior is consistent with quality, efficiency, and evidence-based
21 best practices;

22 (h) Establishing a mechanism for payment of commissions when a
23 small group is enrolled in the partnership by a health insurance broker
24 or solicitor licensed under chapter 48.17 RCW or by an association or
25 member-governed group;

26 (i) Establishing a mechanism to apply a surcharge to all health
27 benefit plans, which shall be used only to pay for administrative and
28 operational expenses of the partnership. The surcharge must be applied
29 uniformly to all health benefit plans offered through the partnership
30 and must be included in the premium for each health plan. As part of
31 the premium, the surcharge shall be subject to the premium tax under
32 RCW 48.14.020. Surcharges may not be used to pay any premium
33 assistance payments under this chapter; and

34 (j) Entering into interdepartmental agreements with the health care
35 authority, the office of the insurance commissioner, the department of
36 social and health services, and any other state agencies necessary to
37 implement this chapter; and

1 (3) An expectation that the successful bidder will begin offering
2 health benefit plans under this act on July 1, 2009, following an open
3 enrollment period that begins on April 1, 2009. With approval of the
4 board established in section 204 of this act, the authority shall
5 notify the apparently successful bidder no later than October 1, 2008.

6 NEW SECTION. **Sec. 204.** (1) The Washington health insurance
7 partnership board is hereby established. The function of the board is
8 to:

9 (a) Provide consultation regarding, and approve:

10 (i) The request for proposal issued under sections 202 and 203 of
11 this act;

12 (ii) The choice of the successful bidder to the request for
13 proposal issued under sections 202 and 203 of this act;

14 (iii) The health plan designs eligible for premium assistance
15 payments under section 205 of this act;

16 (iv) Policies for operation of the partnership developed by the
17 successful bidder;

18 (b) Conduct analyses and provide recommendations as requested by
19 the legislature and the governor, with the assistance of the successful
20 bidder, and staff from the health care authority and the office of the
21 insurance commissioner.

22 (2) The board shall be composed of twelve members appointed by the
23 governor as follows:

24 (a) A member in good standing of the American academy of actuaries;

25 (b) Two representatives of small businesses;

26 (c) Two employee health plan benefits specialists;

27 (d) Two representatives of health care consumers;

28 (e) A physician licensed in good standing under chapter 18.57 RCW;

29 (f) A health insurance broker licensed in good standing under
30 chapter 48.17 RCW;

31 (g) The assistant secretary of the department of social and health
32 services, health recovery services administration;

33 (h) The commissioner; and

34 (i) The administrator.

35 (3) The governor shall appoint the initial members of the board to
36 staggered terms not to exceed four years. Initial appointments shall
37 be made on or before June 1, 2007. Members appointed thereafter shall

1 serve two-year terms. Members of the board shall be compensated in
2 accordance with RCW 43.03.250 and shall be reimbursed for their travel
3 expenses while on official business in accordance with RCW 43.03.050
4 and 43.03.060. The board shall prescribe rules for the conduct of its
5 business. The board shall choose a chair and a vice-chair from among
6 its members. Meetings of the board shall be at the call of the chair.

7 (4) The board may establish technical advisory committees or seek
8 the advice of technical experts when necessary to execute the powers
9 and duties included in this section.

10 (5) The board and employees of the board shall not be civilly or
11 criminally liable and shall not have any penalty or cause of action of
12 any nature arise against them for any action taken or not taken,
13 including any discretionary decision or failure to make a discretionary
14 decision, when the action or inaction is done in good faith and in the
15 performance of the powers and duties under this chapter. Nothing in
16 this section prohibits legal actions against the board to enforce the
17 board's statutory or contractual duties or obligations.

18 NEW SECTION. **Sec. 205.** PREMIUM ASSISTANCE PROGRAM. (1) The

19 successful bidder shall administer the partnership premium assistance
20 program established in this section and remit premium assistance
21 payments made on behalf of eligible partnership participants to
22 carriers offering health plans through the partnership.

23 (2) In consultation with and upon approval by the partnership
24 board, the authority shall designate health plans that qualify for
25 premium assistance payments. At least four health plans shall be
26 chosen, with multiple deductible and point-of-service cost-sharing
27 options. The health plans shall range from catastrophic to
28 comprehensive coverage. One health plan shall include services and
29 cost-sharing comparable to those offered through the basic health plan
30 under chapter 70.47 RCW, as of January 1, 2007. Designated health
31 plans must include innovative components that will maximize the quality
32 of care provided and result in improved health outcomes. These
33 components include, but are not limited to:

34 (a) Preventive care;

35 (b) Wellness incentives, such as personal health assessments with
36 health coaching, and smoking cessation benefits;

1 (c) Limited cost-sharing for preventive services, medications to
2 manage chronic illness, and chronic care management visits;

3 (d) Payment for chronic care services, such as increased
4 reimbursement for primary care visits, reimbursement for care
5 coordination services, and coverage of group visits, telephone
6 consultation, and nutrition education that enable patients to learn the
7 skills needed to manage their chronic illness;

8 (e) Provider network development and payment policies related to
9 quality of care, such as tiered networks, payment for performance in
10 areas such as use of evidence-based protocols, delivery of preventive
11 and chronic care management services, and quality and outcomes
12 reporting.

13 (3) In consultation with and upon approval by the partnership
14 board, the authority shall design a schedule of premium assistance
15 payments that is based upon gross family income, giving appropriate
16 consideration to family size and the ages of all family members. The
17 benchmark plan for purposes of designing the premium assistance payment
18 schedule shall be the benefit design comparable to the basic health
19 plan designated under subsection (2) of this section.

20 For employees of participating small employer plans, the premium
21 assistance schedule shall be applied to the employee premium obligation
22 remaining after employer premium contributions, so that employees
23 benefit financially from their employer's contribution to the cost of
24 their coverage through the partnership. Any surcharge included in the
25 premium under section 203 of this act shall be included when
26 determining the appropriate level of premium assistance payments.

27 (4) A financial sponsor may, with the prior approval of the
28 administrator, pay the premium or any other amount on behalf of a
29 partnership participant, by arrangement with the participant and
30 through a mechanism acceptable to the administrator and the
31 partnership.

32 (5) Beginning January 1, 2009, the successful bidder shall accept
33 applications for premium assistance from partnership participants who
34 have family income up to two hundred percent of the federal poverty
35 level, as determined annually by the federal department of health and
36 human services, on behalf of themselves, their spouses, and their
37 dependent children.

1 (6) The successful bidder shall remit premium assistance payments
2 in an amount determined under subsection (3) of this section to the
3 carrier offering the health plan in which the partnership participant
4 has chosen to enroll. If, however, the partnership participant has
5 chosen to enroll in a high deductible health plan, any difference
6 between the amount of premium assistance that the participant would
7 receive and the applicable premium rate for the high deductible health
8 plan shall be deposited into a health savings account for the benefit
9 of that participant.

10 NEW SECTION. **Sec. 206.** Enrollment in the partnership premium
11 assistance program is not an entitlement and shall not result in
12 expenditures that exceed the amount that has been appropriated for the
13 program in the operating budget. If it appears that continued
14 enrollment will result in expenditures exceeding the appropriated level
15 for a particular fiscal year, the successful bidder may freeze new
16 enrollment in the program and establish a waiting list of eligible
17 employees who shall receive subsidies only when sufficient funds are
18 available.

19 NEW SECTION. **Sec. 207.** PARTNERSHIP PREMIUM ASSISTANCE ACCOUNT.
20 The partnership premium assistance account is hereby established in the
21 custody of the state treasurer. Any nongeneral fund--state funds
22 obtained for the partnership premium assistance program and any funds
23 appropriated for premium assistance under section 205 of this act shall
24 be deposited in the partnership premium assistance account. Moneys in
25 the account shall be used exclusively for the purposes of administering
26 the partnership premium assistance program, including payments to
27 carriers on behalf of partnership participants. Only the administrator
28 or his or her designee may authorize expenditures from the account and
29 make transfers from the account to the successful bidder for
30 administration of the partnership premium assistance program. The
31 account is subject to allotment procedures under chapter 43.88 RCW, but
32 an appropriation is not required for expenditures.

33 NEW SECTION. **Sec. 208.** FINANCIAL REPORT. The partnership shall
34 keep an accurate account of all its activities and of all its receipts
35 and expenditures and shall annually make a report as of the end of its

1 fiscal year to the partnership board, to the governor, and to the
2 legislature. The board may investigate the affairs of the partnership,
3 may examine the properties and records of the partnership, and may
4 prescribe methods of accounting and the rendering of periodical reports
5 in relation to projects undertaken by the partnership.

6 NEW SECTION. **Sec. 209.** REPORTS. No later than two years after
7 the partnership begins operation and every year thereafter, the
8 authority shall conduct a study of the partnership and the persons
9 enrolled in the partnership and shall submit a written report to the
10 governor and the legislature on the status and activities of the
11 partnership based on data collected in the study. The report shall
12 also be available to the general public. The study shall review:

13 (1) The operation and administration of the partnership, including
14 surveys and reports of health benefit plans available to partnership
15 participants and on the experience of the plans. The experience of the
16 plans shall include data on enrollees in the partnership, the number of
17 carriers offering coverage through the partnership, the health plans
18 offered through the partnership, the operation and administration of
19 the partnership premium assistance program, complaints data,
20 partnership expenses, whether and how the partnership met its goals,
21 and other information deemed pertinent by the authority; and

22 (2) Any significant observations regarding utilization and adoption
23 of the partnership.

24 NEW SECTION. **Sec. 210.** REPORT ON PARTICIPATION OF ADDITIONAL
25 MARKETS IN THE PARTNERSHIP AND INDIVIDUAL RESPONSIBILITY. On or before
26 December 1, 2009, the partnership board shall submit a report and
27 recommendations to the governor and the legislature regarding:

28 (1) The risks and benefits of additional markets participating in
29 the partnership:

30 (a) The report shall examine the following markets:

31 (i) Association health plans;

32 (ii) Individual health insurance market;

33 (iii) Washington state health insurance pool under chapter 48.41
34 RCW;

35 (iv) Basic health plan, under chapter 70.47 RCW;

1 (v) Public employees' benefits board enrollees under chapter 41.05
2 RCW; and

3 (vi) Public school employees; and

4 (b) The report shall examine at least the following issues:

5 (i) The impact of these markets participating in the partnership,
6 with respect to the utilization of services and cost of health plans
7 offered through the partnership;

8 (ii) Whether any distinction should be made in participation
9 between active and retired employees enrolled in public employees'
10 benefits board plans, giving consideration to the implicit subsidy that
11 nonmedicare-eligible retirees currently benefit from by being pooled
12 with active employees, and how medicare-eligible retirees would be
13 affected;

14 (iii) The impact of applying the insurance regulations in section
15 302 of this act, RCW 48.43.015, 48.43.025, and 48.43.035, on access to
16 health services and the cost of coverage for these markets; and

17 (iv) If the board recommends the inclusion of additional markets,
18 how the composition of the board should be modified to reflect the
19 participation of these markets.

20 (2) The risks and benefits of establishing a requirement that
21 residents of the state of Washington age eighteen and over obtain and
22 maintain affordable creditable coverage, as defined in the federal
23 health insurance portability and accountability act of 1996 (42 U.S.C.
24 Sec. 300gg(c)). The report shall address the question of how a
25 requirement that residents maintain coverage could be enforced in the
26 state of Washington.

27 NEW SECTION. **Sec. 211.** RULES. The administrator may adopt any
28 rules necessary to implement this chapter.

29 **PART III: INSURANCE REGULATION OF HEALTH BENEFIT PLANS**
30 **OFFERED THROUGH THE PARTNERSHIP**

31 **Sec. 301.** RCW 48.43.005 and 2006 c 25 s 16 are each amended to
32 read as follows:

33 Unless otherwise specifically provided, the definitions in this
34 section apply throughout this chapter.

1 (1) "Adjusted community rate" means the rating method used to
2 establish the premium for health plans adjusted to reflect actuarially
3 demonstrated differences in utilization or cost attributable to
4 geographic region, age, family size, and use of wellness activities.

5 (2) "Basic health plan" means the plan described under chapter
6 70.47 RCW, as revised from time to time.

7 (3) "Basic health plan model plan" means a health plan as required
8 in RCW 70.47.060(2)(e).

9 (4) "Basic health plan services" means that schedule of covered
10 health services, including the description of how those benefits are to
11 be administered, that are required to be delivered to an enrollee under
12 the basic health plan, as revised from time to time.

13 (5) "Catastrophic health plan" means:

14 (a) In the case of a contract, agreement, or policy covering a
15 single enrollee, a health benefit plan requiring a calendar year
16 deductible of, at a minimum, one thousand five hundred dollars and an
17 annual out-of-pocket expense required to be paid under the plan (other
18 than for premiums) for covered benefits of at least three thousand
19 dollars; and

20 (b) In the case of a contract, agreement, or policy covering more
21 than one enrollee, a health benefit plan requiring a calendar year
22 deductible of, at a minimum, three thousand dollars and an annual out-
23 of-pocket expense required to be paid under the plan (other than for
24 premiums) for covered benefits of at least five thousand five hundred
25 dollars; or

26 (c) Any health benefit plan that provides benefits for hospital
27 inpatient and outpatient services, professional and prescription drugs
28 provided in conjunction with such hospital inpatient and outpatient
29 services, and excludes or substantially limits outpatient physician
30 services and those services usually provided in an office setting.

31 (6) "Certification" means a determination by a review organization
32 that an admission, extension of stay, or other health care service or
33 procedure has been reviewed and, based on the information provided,
34 meets the clinical requirements for medical necessity, appropriateness,
35 level of care, or effectiveness under the auspices of the applicable
36 health benefit plan.

37 (7) "Concurrent review" means utilization review conducted during
38 a patient's hospital stay or course of treatment.

1 (8) "Covered person" or "enrollee" means a person covered by a
2 health plan including an enrollee, subscriber, policyholder,
3 beneficiary of a group plan, or individual covered by any other health
4 plan.

5 (9) "Dependent" means, at a minimum, the enrollee's legal spouse
6 and unmarried dependent children who qualify for coverage under the
7 enrollee's health benefit plan.

8 (10) "Eligible employee" means an employee who works on a full-time
9 basis with a normal work week of thirty or more hours. The term
10 includes a self-employed individual, including a sole proprietor, a
11 partner of a partnership, and may include an independent contractor, if
12 the self-employed individual, sole proprietor, partner, or independent
13 contractor is included as an employee under a health benefit plan of a
14 small employer, but does not work less than thirty hours per week and
15 derives at least seventy-five percent of his or her income from a trade
16 or business through which he or she has attempted to earn taxable
17 income and for which he or she has filed the appropriate internal
18 revenue service form. Persons covered under a health benefit plan
19 pursuant to the consolidated omnibus budget reconciliation act of 1986
20 shall not be considered eligible employees for purposes of minimum
21 participation requirements of chapter 265, Laws of 1995.

22 (11) "Emergency medical condition" means the emergent and acute
23 onset of a symptom or symptoms, including severe pain, that would lead
24 a prudent layperson acting reasonably to believe that a health
25 condition exists that requires immediate medical attention, if failure
26 to provide medical attention would result in serious impairment to
27 bodily functions or serious dysfunction of a bodily organ or part, or
28 would place the person's health in serious jeopardy.

29 (12) "Emergency services" means otherwise covered health care
30 services medically necessary to evaluate and treat an emergency medical
31 condition, provided in a hospital emergency department.

32 (13) "Enrollee point-of-service cost-sharing" means amounts paid to
33 health carriers directly providing services, health care providers, or
34 health care facilities by enrollees and may include copayments,
35 coinsurance, or deductibles.

36 (14) "Grievance" means a written complaint submitted by or on
37 behalf of a covered person regarding: (a) Denial of payment for
38 medical services or nonprovision of medical services included in the

1 covered person's health benefit plan, or (b) service delivery issues
2 other than denial of payment for medical services or nonprovision of
3 medical services, including dissatisfaction with medical care, waiting
4 time for medical services, provider or staff attitude or demeanor, or
5 dissatisfaction with service provided by the health carrier.

6 (15) "Health care facility" or "facility" means hospices licensed
7 under chapter 70.127 RCW, hospitals licensed under chapter 70.41 RCW,
8 rural health care facilities as defined in RCW 70.175.020, psychiatric
9 hospitals licensed under chapter 71.12 RCW, nursing homes licensed
10 under chapter 18.51 RCW, community mental health centers licensed under
11 chapter 71.05 or 71.24 RCW, kidney disease treatment centers licensed
12 under chapter 70.41 RCW, ambulatory diagnostic, treatment, or surgical
13 facilities licensed under chapter 70.41 RCW, drug and alcohol treatment
14 facilities licensed under chapter 70.96A RCW, and home health agencies
15 licensed under chapter 70.127 RCW, and includes such facilities if
16 owned and operated by a political subdivision or instrumentality of the
17 state and such other facilities as required by federal law and
18 implementing regulations.

19 (16) "Health care provider" or "provider" means:

20 (a) A person regulated under Title 18 or chapter 70.127 RCW, to
21 practice health or health-related services or otherwise practicing
22 health care services in this state consistent with state law; or

23 (b) An employee or agent of a person described in (a) of this
24 subsection, acting in the course and scope of his or her employment.

25 (17) "Health care service" means that service offered or provided
26 by health care facilities and health care providers relating to the
27 prevention, cure, or treatment of illness, injury, or disease.

28 (18) "Health carrier" or "carrier" means a disability insurer
29 regulated under chapter 48.20 or 48.21 RCW, a health care service
30 contractor as defined in RCW 48.44.010, or a health maintenance
31 organization as defined in RCW 48.46.020.

32 (19) "Health plan" or "health benefit plan" means any policy,
33 contract, or agreement offered by a health carrier to provide, arrange,
34 reimburse, or pay for health care services except the following:

35 (a) Long-term care insurance governed by chapter 48.84 RCW;

36 (b) Medicare supplemental health insurance governed by chapter
37 48.66 RCW;

- 1 (c) Coverage supplemental to the coverage provided under chapter
2 55, Title 10, United States Code;
- 3 (d) Limited health care services offered by limited health care
4 service contractors in accordance with RCW 48.44.035;
- 5 (e) Disability income;
- 6 (f) Coverage incidental to a property/casualty liability insurance
7 policy such as automobile personal injury protection coverage and
8 homeowner guest medical;
- 9 (g) Workers' compensation coverage;
- 10 (h) Accident only coverage;
- 11 (i) Specified disease and hospital confinement indemnity when
12 marketed solely as a supplement to a health plan;
- 13 (j) Employer-sponsored self-funded health plans;
- 14 (k) Dental only and vision only coverage; and
- 15 (l) Plans deemed by the insurance commissioner to have a short-term
16 limited purpose or duration, or to be a student-only plan that is
17 guaranteed renewable while the covered person is enrolled as a regular
18 full-time undergraduate or graduate student at an accredited higher
19 education institution, after a written request for such classification
20 by the carrier and subsequent written approval by the insurance
21 commissioner.
- 22 (20) "Material modification" means a change in the actuarial value
23 of the health plan as modified of more than five percent but less than
24 fifteen percent.
- 25 (21) "Participating small employer plan" means a group health plan,
26 as defined in federal law, Sec. 706 of ERISA (29 U.S.C. Sec. 1186),
27 that is sponsored by a small employer and for which the plan sponsor
28 has entered into an agreement with the partnership, in accordance with
29 the provisions of section 203 of this act, for the partnership to offer
30 and administer health insurance benefits for enrollees in the plan.
- 31 (22) "Partnership" means the Washington health insurance
32 partnership established in sections 202 and 203 of this act.
- 33 (23) "Partnership participant" means a person who has been
34 determined by the partnership to be, and continues to be, an employee
35 of a participating small employer plan for purposes of obtaining
36 coverage through the partnership or a former employee of a
37 participating small employer plan who chooses to continue receiving
38 coverage through the partnership following separation from employment.

1 (24) "Preexisting condition" means any medical condition, illness,
2 or injury that existed any time prior to the effective date of
3 coverage.

4 (~~(22)~~) (25) "Premium" means all sums charged, received, or
5 deposited by a health carrier as consideration for a health plan or the
6 continuance of a health plan. Any assessment or any "membership,"
7 "policy," "contract," "service," or similar fee or charge made by a
8 health carrier in consideration for a health plan is deemed part of the
9 premium. "Premium" shall not include amounts paid as enrollee point-
10 of-service cost-sharing.

11 (~~(23)~~) (26) "Review organization" means a disability insurer
12 regulated under chapter 48.20 or 48.21 RCW, health care service
13 contractor as defined in RCW 48.44.010, or health maintenance
14 organization as defined in RCW 48.46.020, and entities affiliated with,
15 under contract with, or acting on behalf of a health carrier to perform
16 a utilization review.

17 (~~(24)~~) (27) "Small employer" or "small group" means any person,
18 firm, corporation, partnership, association, political subdivision,
19 sole proprietor, or self-employed individual that is actively engaged
20 in business that, on at least fifty percent of its working days during
21 the preceding calendar quarter, employed at least two but no more than
22 fifty eligible employees, with a normal work week of thirty or more
23 hours, the majority of whom were employed within this state, and is not
24 formed primarily for purposes of buying health insurance and in which
25 a bona fide employer-employee relationship exists. In determining the
26 number of eligible employees, companies that are affiliated companies,
27 or that are eligible to file a combined tax return for purposes of
28 taxation by this state, shall be considered an employer. Subsequent to
29 the issuance of a health plan to a small employer and for the purpose
30 of determining eligibility, the size of a small employer shall be
31 determined annually. Except as otherwise specifically provided, a
32 small employer shall continue to be considered a small employer until
33 the plan anniversary following the date the small employer no longer
34 meets the requirements of this definition. A self-employed individual
35 or sole proprietor must derive at least seventy-five percent of his or
36 her income from a trade or business through which the individual or
37 sole proprietor has attempted to earn taxable income and for which he
38 or she has filed the appropriate internal revenue service form 1040,

1 schedule C or F, for the previous taxable year except for a self-
2 employed individual or sole proprietor in an agricultural trade or
3 business, who must derive at least fifty-one percent of his or her
4 income from the trade or business through which the individual or sole
5 proprietor has attempted to earn taxable income and for which he or she
6 has filed the appropriate internal revenue service form 1040, for the
7 previous taxable year. A self-employed individual or sole proprietor
8 who is covered as a group of one on the day prior to June 10, 2004,
9 shall also be considered a "small employer" to the extent that
10 individual or group of one is entitled to have his or her coverage
11 renewed as provided in RCW 48.43.035(6).

12 ~~((+25+))~~ (28) "Utilization review" means the prospective,
13 concurrent, or retrospective assessment of the necessity and
14 appropriateness of the allocation of health care resources and services
15 of a provider or facility, given or proposed to be given to an enrollee
16 or group of enrollees.

17 ~~((+26+))~~ (29) "Wellness activity" means an explicit program of an
18 activity consistent with department of health guidelines, such as,
19 smoking cessation, injury and accident prevention, reduction of alcohol
20 misuse, appropriate weight reduction, exercise, automobile and
21 motorcycle safety, blood cholesterol reduction, and nutrition education
22 for the purpose of improving enrollee health status and reducing health
23 service costs.

24 NEW SECTION. **Sec. 302.** HEALTH PLAN RATING METHODOLOGY. Premium
25 rates for health benefit plans sold through the partnership are subject
26 to the following provisions:

27 (1)(a) A carrier offering any health benefit plan through the
28 partnership, or through an association or member-governed group formed
29 specifically for the purpose of purchasing health care, may offer and
30 actively market a health benefit plan featuring a limited schedule of
31 covered health care services. Nothing in this subsection precludes a
32 carrier from offering other health benefit plans that may have more
33 comprehensive benefits than those included in the health benefit plan
34 offered under this subsection. A carrier offering a health benefit
35 plan under this subsection shall clearly disclose all covered benefits
36 to the small employer in a brochure filed with the commissioner.

1 (b) A health benefit plan offered under this subsection shall
2 provide coverage for hospital expenses and services rendered by a
3 physician licensed under chapter 18.57 or 18.71 RCW but is not subject
4 to the requirements of:

5 (i) For disability insurers, RCW 48.21.130, 48.21.140, 48.21.141,
6 48.21.142, 48.21.144, 48.21.146, 48.21.160 through 48.21.197,
7 48.21.200, 48.21.220, 48.21.225, 48.21.230, 48.21.235, 48.21.240,
8 48.21.244, 48.21.250, 48.21.300, 48.21.310, or 48.21.320;

9 (ii) For health care service contractors, RCW 48.44.225, 48.44.240,
10 48.44.245, 48.44.290, 48.44.300, 48.44.310, 48.44.320, 48.44.325,
11 48.44.330, 48.44.335, 48.44.340, 48.44.344, 48.44.360, 48.44.400,
12 48.44.440, 48.44.450, and 48.44.460; and

13 (iii) For health maintenance organizations, RCW 48.46.275,
14 48.46.280, 48.46.285, 48.46.290, 48.46.350, 48.46.355, 48.46.375,
15 48.46.440, 48.46.480, 48.46.510, 48.46.520, and 48.46.530.

16 (2) Nothing in this section prohibits a carrier from offering, or
17 a purchaser from seeking, health benefit plans with benefits in excess
18 of the health benefit plan offered under subsection (1) of this
19 section. All forms, policies, and contracts shall be submitted for
20 approval to the commissioner, and the rates of any plan offered under
21 this section shall be reasonable in relation to the benefits.

22 (3) The carrier shall develop its rates based on an adjusted
23 community rate and may only vary the adjusted community rate for:

- 24 (a) Geographic area;
- 25 (b) Family size;
- 26 (c) Age; and
- 27 (d) Wellness activities.

28 (4) Except as provided in subsection (11)(b) of this section, the
29 adjustment for age in subsection (3)(c) of this section may not use age
30 brackets smaller than five-year increments, which shall begin with age
31 twenty and end with age sixty-five. Participating individuals under
32 the age of twenty shall be treated as those age twenty.

33 (5) The carrier shall be permitted to develop separate rates for
34 individuals age sixty-five or older for coverage for which medicare is
35 the primary payer and coverage for which medicare is not the primary
36 payer. Both rates are subject to the requirements of this section.

37 (6) The permitted rates for any age group shall be no more than

1 three hundred seventy-five percent of the lowest rate for all age
2 groups.

3 (7) A discount for wellness activities is permitted to reflect
4 actuarially justified differences in utilization or cost attributed to
5 such programs.

6 (8) The rate charged for a health benefit plan offered under this
7 section may not be adjusted more frequently than annually except that
8 the premium may be changed to reflect changes in government
9 requirements affecting the health benefit plan.

10 (9) Rating factors shall produce premiums for identical partnership
11 participants that differ only by the amounts attributable to plan
12 design, with the exception of discounts for health improvement
13 programs.

14 (10) For the purposes of this section, a health benefit plan that
15 contains a restricted network provision shall not be considered similar
16 coverage to a health benefit plan that does not contain such a
17 provision, provided that the restrictions of benefits to network
18 providers result in substantial differences in claims costs. A carrier
19 may develop its rates based on claims costs due to network provider
20 reimbursement schedules or type of network. This subsection does not
21 restrict or enhance the portability of benefits as provided in RCW
22 48.43.015.

23 (11)(a) Except to the extent provided otherwise in (b) of this
24 subsection, adjusted community rates established under this section
25 shall pool the medical experience of all of a carrier's enrollees
26 purchasing coverage through the partnership. However, annual rate
27 adjustments for each partnership plan may vary by up to plus or minus
28 four percentage points from the overall adjustment of a carrier's
29 entire partnership pool, such overall adjustment to be approved by the
30 commissioner, upon a showing by the carrier, certified by a member of
31 the American academy of actuaries that: (i) The variation is a result
32 of deductible leverage, benefit design, or provider network
33 characteristics; and (ii) for a rate renewal period, the projected
34 weighted average of all partnership health benefit plans will have a
35 revenue neutral effect on the carrier's partnership pool. Variations
36 of greater than four percentage points are subject to review by the
37 commissioner, and must be approved or denied within sixty days of
38 submittal. A variation that is not denied within sixty days shall be

1 deemed approved. The commissioner must provide to the carrier a
2 detailed actuarial justification for any denial within thirty days of
3 the denial.

4 (b) Carriers may treat persons under age thirty as a separate
5 experience pool for purposes of establishing rates for health plans
6 offered through the partnership. If the carrier chooses to create a
7 separate experience pool for persons under age thirty, that experience
8 pool is not subject to subsections (4) and (6) of this section.
9 Individuals under age twenty must be rated as one age category.
10 Adjustments for age for persons age twenty up to age thirty may not use
11 age brackets smaller than five-year increments.

12 (12) Nothing in this section restricts the right of employees to
13 collectively bargain for insurance providing benefits in excess of
14 those provided in this section.

15 (13) A carrier must offer coverage to all partnership participants
16 and their dependents. A carrier may not offer coverage to only certain
17 partnership participants. A carrier may not modify a health plan with
18 respect to a partnership participant or dependent, through riders,
19 endorsements, or otherwise, to restrict or exclude coverage or benefits
20 for specific diseases, medical conditions, or services otherwise
21 covered by the plan.

22 **Sec. 303.** RCW 48.43.015 and 2004 c 192 s 5 are each amended to
23 read as follows:

24 (1) For a health benefit plan offered to a group or through the
25 partnership established in sections 202 and 203 of this act, every
26 health carrier shall reduce any preexisting condition exclusion,
27 limitation, or waiting period in the group health plan in accordance
28 with the provisions of section 2701 of the federal health insurance
29 portability and accountability act of 1996 (42 U.S.C. Sec. 300gg).

30 (2) For a health benefit plan offered to a group other than a small
31 group:

32 (a) If the individual applicant's immediately preceding health plan
33 coverage terminated during the period beginning ninety days and ending
34 sixty-four days before the date of application for the new plan and
35 such coverage was similar and continuous for at least three months,
36 then the carrier shall not impose a waiting period for coverage of
37 preexisting conditions under the new health plan.

1 (b) If the individual applicant's immediately preceding health plan
2 coverage terminated during the period beginning ninety days and ending
3 sixty-four days before the date of application for the new plan and
4 such coverage was similar and continuous for less than three months,
5 then the carrier shall credit the time covered under the immediately
6 preceding health plan toward any preexisting condition waiting period
7 under the new health plan.

8 (c) For the purposes of this subsection, a preceding health plan
9 includes an employer-provided self-funded health plan, the basic health
10 plan's offering to health coverage tax credit eligible enrollees as
11 established by chapter 192, Laws of 2004, and plans of the Washington
12 state health insurance pool.

13 (3) For a health benefit plan offered (~~(to a small group)~~) through
14 the partnership established in sections 202 and 203 of this act:

15 (a) If the individual applicant's immediately preceding health plan
16 coverage terminated during the period beginning ninety days and ending
17 sixty-four days before the date of application for the new plan and
18 such coverage was similar and continuous for at least nine months, then
19 the carrier shall not impose a waiting period for coverage of
20 preexisting conditions under the new health plan.

21 (b) If the individual applicant's immediately preceding health plan
22 coverage terminated during the period beginning ninety days and ending
23 sixty-four days before the date of application for the new plan and
24 such coverage was similar and continuous for less than nine months,
25 then the carrier shall credit the time covered under the immediately
26 preceding health plan toward any preexisting condition waiting period
27 under the new health plan.

28 (c) For the purpose of this subsection, a preceding health plan
29 includes an employer-provided self-funded health plan, the basic health
30 plan's offering to health coverage tax credit eligible enrollees as
31 established by chapter 192, Laws of 2004, and plans of the Washington
32 state health insurance pool.

33 (4) For a health benefit plan offered to an individual, other than
34 an individual to whom subsection (5) of this section applies, every
35 health carrier shall credit any preexisting condition waiting period in
36 that plan for a person who was enrolled at any time during the sixty-
37 three day period immediately preceding the date of application for the
38 new health plan in a group health benefit plan or an individual health

1 benefit plan, other than a catastrophic health plan, and (a) the
2 benefits under the previous plan provide equivalent or greater overall
3 benefit coverage than that provided in the health benefit plan the
4 individual seeks to purchase; or (b) the person is seeking an
5 individual health benefit plan due to his or her change of residence
6 from one geographic area in Washington state to another geographic area
7 in Washington state where his or her current health plan is not
8 offered, if application for coverage is made within ninety days of
9 relocation; or (c) the person is seeking an individual health benefit
10 plan: (i) Because a health care provider with whom he or she has an
11 established care relationship and from whom he or she has received
12 treatment within the past twelve months is no longer part of the
13 carrier's provider network under his or her existing Washington
14 individual health benefit plan; and (ii) his or her health care
15 provider is part of another carrier's provider network; and (iii)
16 application for a health benefit plan under that carrier's provider
17 network individual coverage is made within ninety days of his or her
18 provider leaving the previous carrier's provider network. The carrier
19 must credit the period of coverage the person was continuously covered
20 under the immediately preceding health plan toward the waiting period
21 of the new health plan. For the purposes of this subsection (4), a
22 preceding health plan includes an employer-provided self-funded health
23 plan, the basic health plan's offering to health coverage tax credit
24 eligible enrollees as established by chapter 192, Laws of 2004, and
25 plans of the Washington state health insurance pool.

26 (5) Every health carrier shall waive any preexisting condition
27 waiting period in its individual plans for a person who is an eligible
28 individual as defined in section 2741(b) of the federal health
29 insurance portability and accountability act of 1996 (42 U.S.C. Sec.
30 300gg-41(b)).

31 (6) Subject to the provisions of subsections (1) through (5) of
32 this section, nothing contained in this section requires a health
33 carrier to amend a health plan to provide new benefits in its existing
34 health plans. In addition, nothing in this section requires a carrier
35 to waive benefit limitations not related to an individual or group's
36 preexisting conditions or health history.

1 **Sec. 304.** RCW 48.43.025 and 2001 c 196 s 9 are each amended to
2 read as follows:

3 (1) For group health benefit plans for groups other than small
4 groups, no carrier may reject an individual for health plan coverage
5 based upon preexisting conditions of the individual and no carrier may
6 deny, exclude, or otherwise limit coverage for an individual's
7 preexisting health conditions; except that a carrier may impose a
8 three-month benefit waiting period for preexisting conditions for which
9 medical advice was given, or for which a health care provider
10 recommended or provided treatment within three months before the
11 effective date of coverage. Any preexisting condition waiting period
12 or limitation relating to pregnancy as a preexisting condition shall be
13 imposed only to the extent allowed in the federal health insurance
14 portability and accountability act of 1996.

15 (2) For group health benefit plans (~~((for small groups))~~) offered
16 through the partnership established in sections 202 and 203 of this
17 act, no carrier may reject an individual for health plan coverage based
18 upon preexisting conditions of the individual and no carrier may deny,
19 exclude, or otherwise limit coverage for an individual's preexisting
20 health conditions. Except that a carrier may impose a nine-month
21 benefit waiting period for preexisting conditions for which medical
22 advice was given, or for which a health care provider recommended or
23 provided treatment within six months before the effective date of
24 coverage. Any preexisting condition waiting period or limitation
25 relating to pregnancy as a preexisting condition shall be imposed only
26 to the extent allowed in the federal health insurance portability and
27 accountability act of 1996.

28 (3) No carrier may avoid the requirements of this section through
29 the creation of a new rate classification or the modification of an
30 existing rate classification. A new or changed rate classification
31 will be deemed an attempt to avoid the provisions of this section if
32 the new or changed classification would substantially discourage
33 applications for coverage from individuals or groups who are higher
34 than average health risks. These provisions apply only to individuals
35 who are Washington residents.

36 **Sec. 305.** RCW 48.43.035 and 2004 c 244 s 4 are each amended to
37 read as follows:

1 For group health benefit plans and for health benefit plans offered
2 through the partnership established in sections 202 and 203 of this
3 act, the following shall apply:

4 (1) All health carriers shall accept for enrollment any state
5 resident within the group to whom the plan is offered and within the
6 carrier's service area and provide or assure the provision of all
7 covered services regardless of age, sex, family structure, ethnicity,
8 race, health condition, geographic location, employment status,
9 socioeconomic status, other condition or situation, or the provisions
10 of RCW 49.60.174(2). The insurance commissioner may grant a temporary
11 exemption from this subsection, if, upon application by a health
12 carrier the commissioner finds that the clinical, financial, or
13 administrative capacity to serve existing enrollees will be impaired if
14 a health carrier is required to continue enrollment of additional
15 eligible individuals.

16 (2) Except as provided in subsection (5) of this section, all
17 health plans shall contain or incorporate by endorsement a guarantee of
18 the continuity of coverage of the plan. For the purposes of this
19 section, a plan is "renewed" when it is continued beyond the earliest
20 date upon which, at the carrier's sole option, the plan could have been
21 terminated for other than nonpayment of premium. The carrier may
22 consider the group's anniversary date as the renewal date for purposes
23 of complying with the provisions of this section.

24 (3) The guarantee of continuity of coverage required in health
25 plans shall not prevent a carrier from canceling or nonrenewing a
26 health plan for:

27 (a) Nonpayment of premium;

28 (b) Violation of published policies of the carrier approved by the
29 insurance commissioner;

30 (c) Covered persons entitled to become eligible for medicare
31 benefits by reason of age who fail to apply for a medicare supplement
32 plan or medicare cost, risk, or other plan offered by the carrier
33 pursuant to federal laws and regulations;

34 (d) Covered persons who fail to pay any deductible or copayment
35 amount owed to the carrier and not the provider of health care
36 services;

37 (e) Covered persons committing fraudulent acts as to the carrier;

38 (f) Covered persons who materially breach the health plan; or

1 (g) Change or implementation of federal or state laws that no
2 longer permit the continued offering of such coverage.

3 (4) The provisions of this section do not apply in the following
4 cases:

5 (a) A carrier has zero enrollment on a product;

6 (b) A carrier replaces a product and the replacement product is
7 provided to all covered persons within that class or line of business,
8 includes all of the services covered under the replaced product, and
9 does not significantly limit access to the kind of services covered
10 under the replaced product. The health plan may also allow
11 unrestricted conversion to a fully comparable product;

12 (c) No sooner than January 1, 2005, a carrier discontinues offering
13 a particular type of health benefit plan offered for groups of up to
14 two hundred if: (i) The carrier provides notice to each group of the
15 discontinuation at least ninety days prior to the date of the
16 discontinuation; (ii) the carrier offers to each group provided
17 coverage of this type the option to enroll, with regard to small
18 employer groups, in any other small employer group plan, or with regard
19 to groups of up to two hundred, in any other applicable group plan,
20 currently being offered by the carrier in the applicable group market;
21 and (iii) in exercising the option to discontinue coverage of this type
22 and in offering the option of coverage under (c)(ii) of this
23 subsection, the carrier acts uniformly without regard to any health
24 status-related factor of enrolled individuals or individuals who may
25 become eligible for this coverage;

26 (d) A carrier discontinues offering all health coverage in the
27 small group market or for groups of up to two hundred, or both markets,
28 in the state and discontinues coverage under all existing group health
29 benefit plans in the applicable market involved if: (i) The carrier
30 provides notice to the commissioner of its intent to discontinue
31 offering all such coverage in the state and its intent to discontinue
32 coverage under all such existing health benefit plans at least one
33 hundred eighty days prior to the date of the discontinuation of
34 coverage under all such existing health benefit plans; and (ii) the
35 carrier provides notice to each covered group of the intent to
36 discontinue the existing health benefit plan at least one hundred
37 eighty days prior to the date of discontinuation. In the case of
38 discontinuation under this subsection, the carrier may not issue any

1 group health coverage in this state in the applicable group market
2 involved for a five-year period beginning on the date of the
3 discontinuation of the last health benefit plan not so renewed. This
4 subsection (4) does not require a carrier to provide notice to the
5 commissioner of its intent to discontinue offering a health benefit
6 plan to new applicants when the carrier does not discontinue coverage
7 of existing enrollees under that health benefit plan; or

8 (e) A carrier is withdrawing from a service area or from a segment
9 of its service area because the carrier has demonstrated to the
10 insurance commissioner that the carrier's clinical, financial, or
11 administrative capacity to serve enrollees would be exceeded.

12 (5) The provisions of this section do not apply to health plans
13 deemed by the insurance commissioner to be unique or limited or have a
14 short-term purpose, after a written request for such classification by
15 the carrier and subsequent written approval by the insurance
16 commissioner.

17 (6) Notwithstanding any other provision of this section, the
18 guarantee of continuity of coverage applies to a group of one only if:

19 (a) The carrier continues to offer any other small employer group plan
20 in which the group of one was eligible to enroll on the day prior to
21 June 10, 2004; and (b) the person continues to qualify as a group of
22 one under the criteria in place on the day prior to June 10, 2004.

23 NEW SECTION. Sec. 306. INSURANCE MARKET CONSOLIDATION IN THE
24 PARTNERSHIP. A carrier shall not issue or renew a small group health
25 benefit plan to a small employer other than through the partnership
26 established in sections 202 and 203 of this act after January 1, 2009.

27 **Sec. 307.** RCW 48.21.047 and 2005 c 223 s 11 are each amended to
28 read as follows:

29 (1) An insurer may not offer any health benefit plan (~~(to any small~~
30 ~~employer without complying with RCW 48.21.045(3))~~ through the
31 partnership established in sections 202 and 203 of this act without
32 complying with section 302 of this act.

33 (2) Employers purchasing health plans provided through associations
34 or through member-governed groups formed specifically for the purpose
35 of purchasing health care are not small employers and the plans are not
36 subject to (~~RCW 48.21.045(3))~~ section 302(3) of this act.

1 (3) For purposes of this section, "health benefit plan," "health
2 plan," and "small employer" mean the same as defined in RCW 48.43.005.

3 **Sec. 308.** RCW 48.44.024 and 2003 c 248 s 15 are each amended to
4 read as follows:

5 (1) A health care service contractor may not offer any health
6 benefit plan (~~((to any small employer without complying with RCW
7 48.44.023(3)))~~) through the partnership established in sections 202 and
8 203 of this act without complying with section 302 of this act.

9 (2) Employers purchasing health plans provided through associations
10 or through member-governed groups formed specifically for the purpose
11 of purchasing health care are not small employers and the plans are not
12 subject to (~~(RCW 48.44.023(3))~~) section 302(3) of this act.

13 (3) For purposes of this section, "health benefit plan," "health
14 plan," and "small employer" mean the same as defined in RCW 48.43.005.

15 **Sec. 309.** RCW 48.46.068 and 2003 c 248 s 16 are each amended to
16 read as follows:

17 (1) A health maintenance organization may not offer any health
18 benefit plan (~~((to any small employer without complying with RCW
19 48.46.066(3)))~~) through the partnership established in sections 202 and
20 203 of this act without complying with section 302 of this act.

21 (2) Employers purchasing health plans provided through associations
22 or through member-governed groups formed specifically for the purpose
23 of purchasing health care are not small employers and are not subject
24 to (~~(RCW 48.46.066(3))~~) section 302(3) of this act.

25 (3) For purposes of this section, "health benefit plan," "health
26 plan," and "small employer" mean the same as defined in RCW 48.43.005.

27 **Sec. 310.** RCW 48.43.028 and 2001 c 196 s 10 are each amended to
28 read as follows:

29 To the extent required of the federal health insurance portability
30 and accountability act of 1996, the eligibility of an employer or group
31 to purchase a health benefit plan set forth in (~~(RCW 48.21.045(1)(b),
32 48.44.023(1)(b), and 48.46.066(1)(b))~~) section 302(1) of this act must
33 be extended to all small employers and small groups as defined in RCW
34 48.43.005.

1 NEW SECTION. **Sec. 311.** RULES. The commissioner may adopt any
2 rules necessary to implement this chapter.

3 **PART IV: EMPLOYER RESPONSIBILITY**

4 NEW SECTION. **Sec. 401.** The definitions in this section apply
5 throughout this chapter unless the context clearly requires otherwise.

6 (1) "Employee" means any individual employed by any employer.

7 (2) "Employer" means an employer as defined in RCW 49.46.010.

8 (3) "Partnership" means the entity established in sections 202 and
9 203 of this act.

10 NEW SECTION. **Sec. 402.** Beginning January 1, 2009, each employer
11 that has entered into an agreement with the partnership, in accordance
12 with this act, for the partnership to offer and administer health
13 insurance benefits for its employees shall:

14 (1) Adopt and maintain a cafeteria plan that satisfies 26 U.S.C.
15 Sec. 125 that provides a premium only plan option so that employees can
16 use salary deductions to pay health plan premiums. A copy of such
17 cafeteria plan shall be filed with the partnership; and

18 (2) Collect and transmit amounts designated as payroll deductions
19 by employees to the partnership for those employees purchasing coverage
20 through the partnership.

21 NEW SECTION. **Sec. 403.** The attorney general shall enforce
22 sections 401 and 402 of this act and has the authority to seek and
23 obtain injunctive relief in a court of appropriate jurisdiction.

24 **PART V: INDEPENDENT STUDY OF HEALTH BENEFIT REQUIREMENTS**

25 NEW SECTION. **Sec. 501.** (1) The office of the insurance
26 commissioner shall contract for an independent study of health benefit
27 mandates, rating requirements, and insurance statutes and rules to
28 determine the impact on premiums and individuals' health if those
29 statutes or rules were amended or repealed.

30 (2) The office of the insurance commissioner shall submit an
31 interim report to the governor and appropriate committees of the

1 legislature by December 1, 2007, and a final report by December 1,
2 2008.

3 **PART VI: CONFORMING AMENDMENTS, REPEALERS, AND**
4 **EFFECTIVE DATES**

5 NEW SECTION. **Sec. 601.** (1) Sections 102 and 201 through 211 of
6 this act constitute a new chapter in Title 41 RCW.

7 (2) Sections 302, 306, and 307 of this act are each added to
8 chapter 48.43 RCW.

9 (3) Sections 401 through 403 of this act constitute a new chapter
10 in Title 49 RCW.

11 NEW SECTION. **Sec. 602.** Part headings and captions used in this
12 act are not any part of the law.

13 NEW SECTION. **Sec. 603.** The following acts or parts of acts are
14 each repealed, effective January 1, 2009:

15 (1) RCW 48.21.045 (Health plan benefits for small employers--
16 Coverage--Exemption from statutory requirements--Premium rates--
17 Requirements for providing coverage for small employers--Definitions)
18 and 2004 c 244 s 1, 1995 c 265 s 14, & 1990 c 187 s 2;

19 (2) RCW 48.44.023 (Health plan benefits for small employers--
20 Coverage--Exemption from statutory requirements--Premium rates--
21 Requirements for providing coverage for small employers) and 2004 c 244
22 s 7, 1995 c 265 s 16, & 1990 c 187 s 3;

23 (3) RCW 48.46.066 (Health plan benefits for small employers--
24 Coverage--Exemption from statutory requirements--Premium rates--
25 Requirements for providing coverage for small employers) and 2004 c 244
26 s 9, 1995 c 265 s 18, & 1990 c 187 s 4;

27 (4) RCW 70.47A.010 (Finding--Intent) and 2006 c 255 s 1;

28 (5) RCW 70.47A.020 (Definitions) and 2006 c 255 s 2;

29 (6) RCW 70.47A.030 (Program established--Administrator duties) and
30 2006 c 255 s 3;

31 (7) RCW 70.47A.040 (Premium subsidies--Enrollment verification,
32 status changes--Administrator duties--Rules) and 2006 c 255 s 4;

33 (8) RCW 70.47A.050 (Enrollment to remain within appropriation) and
34 2006 c 255 s 5;

- 1 (9) RCW 70.47A.060 (Rules) and 2006 c 255 s 6;
2 (10) RCW 70.47A.070 (Reports) and 2006 c 255 s 7;
3 (11) RCW 70.47A.080 (Small employer health insurance partnership
4 program account) and 2006 c 255 s 8;
5 (12) RCW 70.47A.090 (State children's health insurance program--
6 Federal waiver request) and 2006 c 255 s 9; and
7 (13) RCW 70.47A.900 (Captions not law--2006 c 255) and 2006 c 255
8 s 11.

9 NEW SECTION. **Sec. 604.** Sections 302 through 310 of this act take
10 effect January 1, 2009.

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